EXHIBIT L

NEW YORK STATE OF OPPORTUNITY.

Justice Center for the Protection of People with Special Needs

ANDREW M. CUOMO
Governor

DENISE M. MIRANDA
Executive Director

January 25, 2019

Donna Hall, Ph.D.
Associate Commissioner
Division of Forensic Services
NYS Office of Mental Health
44 Holland Avenue
Albany, NY 12229

Anthony J. Annucci
Acting Commissioner
NYS Department of Corrections
And Community Supervision
The Harriman State Campus-Building 2
1220 Washington Avenue
Albany, NY 12226-2050

Re: OAI 1-2FNS59J Justice Center Oversight Action

Dear Dr. Hall and Acting Commissioner Annucci:

The Justice Center for the Protection of People with Special Needs (the Justice Center) has completed its review of the mental health services provided to Joseph King (DIN #13A3662), an inmate/patient who died on November 16, 2018 at the Mid-State Correctional Facility (CF). The Justice Center's review found concerns related to the standard of care set forth by the Central New York Psychiatric Center (CNYPC) and the Department of Corrections and Community Supervision (DOCCS). The attached review describes the Justice Center's findings and recommendations.

The Justice Center looks forward to your response to the attached findings and recommendations by February 25, 2019. Please direct any correspondence or concerns related to this review to me at denise.miranda@justicecenter.ny.gov. Thank you for your continued cooperation.

Sincerely,

Denise M. Miranda, Esq.
Executive Director

Cc: Davin Robinson, Deputy Director, Outreach, Prevention & Support
Melissa Finn, Unit Supervisor, Forensics
Ashley Cahill, Facility Review Specialist, Forensics
Ann Sullivan, M.D., Commissioner OMH
Deborah McCulloch, Executive Director, CNYPC
Lori Schatzel, Director, Corrections-Based Operations, OMH
Bryan Hilton, Associate Commissioner, DOCCS
Mitchel Lake, Director, DOCCS Bureau of Mental Health
William Vertoske, Forensic Services Program Administrator 2
Maureen Morrison, OMH
Meaghan Bernstein, OMH

NOTE: All correspondence related to this matter will be available for public inspection under Article 6 of the Public Officers Law. Material which will be required to be kept confidential or which is protected from disclosure under the Public Officers Law or other laws will be redacted prior to such disclosure.

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Justice Center Oversight Action
Mental Health Service Review Joseph King (DIN #13A3662)
JC#: OAI 1-2FNS59J

The Justice Center reviewed documentation related to the care provided by Central New York Psychiatric Center (CNYPC) and the Department of Corrections and Community Supervision (DOCCS) to Joseph King in the six months prior to his suicide.[1] This review found that the Office of Mental Health (OMH) failed to recognize the suicide risk factors and warning signs displayed by Mr. King.

Background

At the time of his death, Mr. King was a 50-year old white male serving his first NYS Bid for Arson in the Third Degree with a sentence of 4-12 years. He had a conditional release date of May 22, 2020 and a maximum release date of May 22, 2024. Prior to incarceration, Mr. King reported receiving outpatient mental health treatment in the community between 2009 and 2013. Mr. King also reported his participation in mental health treatment was inconsistent and he most recently attended for two months prior to incarceration. He endorsed a history of cutting to relieve stress and he would often consume alcohol when engaging in the behavior.

Mr. King entered DOCCS reception at the Clinton Correctional Facility in August 2013 and was admitted to the mental health caseload as a mental health service level (MHSL) 3. Mr. King was diagnosed with Adjustment Disorder with Mixed Anxiety and Depressed Mood, Alcohol and Cannabis Use Disorder in February 2015. According to his Chronological Record, Mr. King was changed to a MHSL 2 in February 2016. On July 11, 2016, Mr. King attempted to hang himself while he was supposed to be at program. He reported he went to a floor where there were no inmates or officers present or expected to be in the area and tied a black shoelace to the security screen and around his neck. He stated the shoelace broke and he fell landing on his nose and forehead. Following the incident, Mr. King reported he returned to his program, completed his work module and went back to his housing unit. Upon return to his unit, he reported the incident to an officer and was examined by medical and the incident was deemed a suicide attempt. Mr. King presented with clear ligature marks, swollen nose and raised bump to the right side of his forehead. Mr. King was admitted to the Residential Crisis Treatment Program (RCTP) and reported to staff at the time that his suicide attempt was due to withdrawing from Suboxone. Mr. King remained in the RCTP until he was transferred to the RCTP dorm on July 19, 2016. On August 4, 2016, Mr. King was deemed a MHSL 1S due to his recent serious suicide attempt. On the same day, he was released from the RCTP to general population at the Mid-State CF. Mr. King remained in general population but was noted to be using Suboxone on and off over the year.

In May 2018, Mr. King continued to be housed in general population at the Mid-State CF. He met with mental health and psychiatric staff on May 14 and reported he needed something to calm down. He stated, "I need something to calm down. I'm not hungry, I'm not eating much,

[1] The Justice Center reviewed documentation for the six months prior to his death. The period reviewed was May 1, 2018 – November 16, 2018.

and I'm not sleeping." He was informed his symptoms were appropriate with his recent loss of his mother, but he was adamant he was struggling prior to the loss and was requesting a medication change; both his prescriptions of Celexa and Vistaril were increased. Mental health staff offered therapeutic worksheets on grief/bereavement, but Mr. King refused them and reported he continued to maintain contact with his family. Mental health and psychiatric staff met with Mr. King in June and he reported, "I'm still depressed, man. I don't feel like doing anything. I have no motivation to do anything." He adamantly denied experiencing thoughts of self-harm. Mr. King reported he had recently received a disciplinary ticket for drug use and stated he had used Suboxone. The psychiatric progress note indicated that all his medications would be tapered and discontinued in order to start over and see which ones would be helpful. Mr. King was reminded of the dangers of using drugs with psychotropic medication. Mental health and psychiatric staff met with Mr. King on July 23 and he reported, "I feel terrible. I have a lot of anxiety." He stated he had been experiencing "panic attacks, pacing, a lot of anxiety. My heart is racing, I can't breathe, I get hot, I can't sit down and I can't sleep. I have to keep moving." Mr. King denied experiencing psychotic symptoms or wanting to harm himself. Sleep hygiene was discussed and he was encouraged to refrain from sleeping during the day and to monitor his caffeine intake. Mr. King was started on Zoloft and Trazadone.

In August, mental health and psychiatric staff met with Mr. King and he described his mood as "edgy, nervous." He reported he was compliant with his medication but did not think it was effectively addressing his symptoms. He was informed his medication would not be increased unless he was actively trying to increase his coping skills. He continued to report experiencing no energy or motivation. He stated, "I lay in bed all day, and I can't sleep. I only get like three or four hours of sleep at night. I'm tired of doing the same thing every day. I can't take this anymore." Mr. King denied wanting to harm himself. He was informed that in the last year he had eliminated several coping skills in place of using substances. Mr. King quit his paint crew job, stopped attending AA/NA meetings, stopped going to religious service, and reported "nothing helps." It was also noted that he was not willing to complete worksheets, attend coping skill groups or actively participate in treatment. Mr. King requested an increase in Trazadone for sleep but was denied and it was reiterated that his medication would not be changed until he attempted to use alternative coping skills. Mental health staff met with Mr. King on September 27 and he reported, "I still feel terrible." He reported he was compliant with his medication but was still experiencing "crazy anxiety, depression and is not motivated to do anything." He denied reviewing any worksheets, using relaxation techniques or attending AA/NA meetings to help him address his substance abuse issues. He was reminded that psychiatric staff was unwilling to make any medication changes if he wasn't willing to comply with treatment recommendations. Mr. King stated he was kicked out of Alcohol and Substance Abuse Treatment Program (ASAT) for a dirty urine ticket and identified playing solitaire and doing crosswords as his main source of coping skills. Psychiatric staff met with Mr. King on October 16 and he reported he needed medication to help him. It was noted, his expected participation in treatment was discussed in detail and he would be placed in group therapy to assist with skill building. His prescription of Zoloft was discontinued, Prozac was started and Trazadone was continued.

Mr. King's call out with mental health staff was cancelled on October 26 and he was rescheduled and seen on November 2; this was his last contact with mental health staff. Mr. King described his mood as "I feel edgy; and worried." He was noted to be refusing his Prozac medication, stating that it makes him feel weird. He reported he finds himself waiting around all day until he receives his Trazadone which is the only time he feels relatively alright. He denied experiencing any psychotic symptoms and when asked about self-harm, he denied and stated, "I'll never do that again." Mr. King expressed he was going to church, attending AA meetings and going to the yard. He stated he was working as a porter and waiting to return to ASAT. Additionally, he continued to maintain contact with his family. However, Mr. King was noted to

continue to express frustration with his inability to deal with reported "edginess, nerve problem." Mental health staff encouraged Mr. King to speak with psychiatric staff about any concerns he had regarding his medication. His medications were discontinued on November 6. On November 16, 2018 during morning rounds, officers observed Mr. King with a shoe string tied around his neck and then tied to an electrical conduit on the ceiling. After attempts to resuscitate him failed, he was pronounced dead.

Justice Center Findings

1. **Mr. King had extensive changes to his medication regimen in the five months prior to his suicide.**

   Mr. King received a disciplinary drug ticket in May 2018 for Suboxone use.[2] Clinical progress notes indicated that Mr. King was reminded of the dangers of using drugs with psychotropic medications. A determination was made on June 25, 2018 to discontinue all medications (Celexa and Vistaril) in order to start over and determine what medications would be helpful. Following complaints of "panic attacks, pacing and a lot of anxiety" in July 2018, Mr. King was prescribed Trazadone and Zoloft. He continued to voice mental health concerns in August and September however clinical staff informed Mr. King that he couldn't be helped if he wasn't willing to help himself and he didn't appear to be motivated for change. During a psychiatric call out in September, his participation in treatment was discussed in detail and it was documented that he would be placed in group therapy to assist with skill building. At that time, his Zoloft was discontinued, Prozac was started and Trazadone was continued. The following month, during Mr. King's last scheduled contact with clinical staff, he acknowledged that he was going to church, attending AA meetings, and going to the yard. It was noted that he had been refusing his Prozac, stating it made him feel weird, and that he finds himself waiting all day to receive his Trazadone because it is the only time he feels relatively all right. Mr. King was then encouraged to speak with psychiatric staff about any concerns he had about his medications, which according to a previous Psychiatric Progress Note, would have been on or around November 30th.[3] Mr. King's Physician's Orders indicate that on November 6, 2018, his medications were discontinued, including his Trazadone. This occurred ten days prior to his suicide, without Mr. King being assessed by psychiatric staff.

2. **OMH failed to recognize the suicide risk factors and warning signs displayed by Mr. King prior to his suicide. Additionally, his symptoms appeared to increase and there was minimal documentary evidence that additional support, programming or crisis intervention was offered.**

   Mr. King had a documented history of a recent suicide attempt in 2016 in which he tried to hang himself and reported that his triggers were being overwhelmed with his prison sentence and substance abuse. His serious suicide attempt met the criteria for a Serious Mental Illness and in August 2016, Mr. King was deemed a MHSL 1S. In the six months prior to his suicide, Mr. King denied wanting to harm himself during his monthly mental health call outs and according to mental health staff, he did not display overt signs of suicidal ideation or evidence any warning signs of acute suicide risk in his behavior or affect. However, he repeatedly reported to mental health staff during his callouts that he was depressed, anxious, worried, not sleeping, had decreased motivation and was

[2] Inmate Misbehavior Report dated May 10, 2018 – Tier III ticket for Drug Use
[3] Psychiatric Progress Note dated October 16, 2018 indicated Mr. King would receive a psychiatric follow-up in 45 days or otherwise clinically indicated.

concerned about his upcoming parole board.[4] In addition, Mr. King's Comprehensive Suicide Risk Assessment Form indicated he had 21 chronic/acute risk factors which included substance use "an identifiable trigger for increased suicide risk." [5]

Three months prior to his death, Mr. King reported experiencing no energy or motivation, "I lay in bed all day, and I can't sleep. I only get like three or four hours of sleep at night. I'm tired of doing the same thing every day. I can't take this anymore." Mr. King asked for medication adjustments but was informed by mental health staff on numerous callouts that his medication would not be changed until he attempted to use alternative coping skills. Mental health staff noted that in the last year, Mr. King had an increase in substance use, quit his paint crew job, stopped attending AA/NA meetings and stopped going to religious services.

In the two weeks leading up to his death, Mr. King continued to express to mental health staff his frustration with his inability to deal with his reported edginess and worry, even though he reported attending church, AA meetings and going to the yard. He expressed concerns with his medication and the way they were making him feel. He was encouraged by mental health staff to speak with psychiatric staff regarding his medication. On November 16, 2018, Mr. King was found hanging in the general population dorm bathroom.

Justice Center Recommendations

1. The OMH Clinical Director or Regional Psychiatrist should complete a comprehensive review of the mental health treatment afforded to Mr. King in the six months leading up to his death and provide the Justice Center with any documentation demonstrating his course of care was reviewed and evaluated to ensure the appropriateness of:
    a. the psychiatric medication administration practices and;
    b. the clinical care provided to an individual with a history of suicide attempts, substance use and chronic/acute suicide risk factor and warning signs.

Review conducted by: Ashley Cahill
Ashley Cahill, Facility Review Specialist

[4] Primary Therapist Progress Note dated May 14, 2018, June 25, 2018, July 23, 2018, August 27, 2018, September 27, 2018 and November 2, 2018.
[5] Comprehensive Suicide Risk Assessment Form updated August 27, 2018